TOUCHSTONE RESIDENTIAL SERVICES

OFFICE 910-791-4595 4620 CEDAR AVENUE, SUITE 118 WILMINGTON, NC 28403 FAX 910-791-4976

Dear Case Manager / Social Worker / Referral Source:

The following is a list of information needed for placement. We look forward to providing the best possible service for your consumer

Thank You,

Child Name: _____

Date of Birth _____ **Record#:** _____ **LME Location:** _____

DSS Agency _____ **PHONE:** _____

Clinical Home/Case Manager _____ **PHONE:** _____

SERVICES BEING REQUESTED:

- ☐ Family Foster Care
- ☐ Family Foster Care Daily Rate
- ☐ Level 2 Mental Health
- ☐ Clinical Home Provider/Case Management

At the time of placement / service

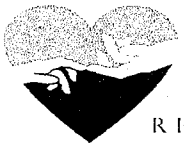
- ☐ Birth Certificate / SS card
- ☐ Financial Agreement (DSS)
- ☐ Other _____

At the time of placement / service

- ☐ TB Screening and Physical
- ☐ Immunization Record
- ☐ Medical Information
- ☐ List of Current Medications
- ☐ Physician orders for Medications
- ☐ Education Records (if applicable)
- ☐ Guardianship Papers (if applicable
- ☐ Court Records (if applicable)
- ☐ Medicaid Card
- ☐ Medication
- ☐ Social History
- ☐ Out of Home Family Services Agreement

REQUIRED INFORMATION (MENTAL HEALTH)

- ☐ CURRENT PCP w/Doctor's signature
- ☐ CURRENT PCP
- ☐ Approved Authorization from Value Options
- ☐ CAFAS / SNAP/ NC TOPPS



TOUCHSTONE
RESIDENTIAL SERVICES

APPLICATION FOR SERVICE

Child's Name: _____ Date of Birth: ____/____/____ Sex: _____ Race: _____
Last First Middle

Address: _____
Street City State Zip Code

Social Security No: ____-____-____ Place of Birth: _____
County State

Is Child "At risk" Certified? _____ Case Manager: _____ Phone: _____

Is Child in DSS Custody? _____ County: _____ Social Worker: _____ Phone: _____

Does Child Receive Medicaid? _____ Medicaid Card No: _____ Issue Date: _____

Current Placement: Biological Parent (s): _____ Relative: _____ Foster Home: _____ Other (Specify): _____

* *

Father's Name: _____

DOB: _____ Race: _____ Religion: _____ Marital Status: _____

Address: _____ Phone: _____

Mother's Name: _____

DOB: _____ Race: _____ Religion: _____ Marital Status: _____

Address: _____ Phone: _____

Child's Siblings: (Include all half, step, and adoptive siblings)

Name	Date of Birth	Relationship	Current Address	Phone #

* *

Reason for Out of Home Placement/Treatment: _____

_____

Reason for Referral: _____

_____

Projected Length of Placement: _____

Long Term Goals: _____

_____

Describe current situation for child: (include family strengths/weaknesses, child's strengths/weaknesses) ____________________

____

____

Please describe: ____________________

____

List Diagnoses: Axis I ____________________

Axis II ____________________

Axis III ____________________

Axis IV ____________________

Axis V ____________________

Does child currently take medication? _____ If yes, please list: ____________________

____

List ALL Allergies: ____________________

____

Behavior Checklist: (Please check any behavior which is current or has been exhibited in the past)

Tantrums _____ Academic Delays _____ Truancy _____ Lying _____ Animal Cruelty_____

Stealing _____ S.I.B. _____ Runaway _____ Aggressive/Assaultive _____

Vandalism _____ Sexually Inappropriate _____ Fire Setting _____ Court Involvement (Criminal Behavior) _____

Suicidal Ideation _____ Suicidal Attempts _____ Sexual Assault _____

Briefly describe checked behaviors or any other significant behaviors: ____________________

____

____

* *

Current School Placement: Grade _____ School: ____________________

School Address: ____________________ Phone: ____________________

Has child been classified as "special needs" under PL 94-142? _____

If so, please indicate classification: (i.e. BED, EMH, etc.) ____________________

* *

Please list and describe any interests, hobbies, activities enjoyed by child: ____________________

____

____

____

List resource professional or volunteers: (i.e. Guardian ad Litem, surrogate parent, therapists, medical specialists, court counselors)

____

____

____

* *

(Page 3) Child's Name: ____________________

Previous Placements:

Name of Provider	Type of Placement (Foster Home, Group Home, Hospital, etc.)	Dates of Placement	Address & Phone Numbers of Placements

* *

For Touchstone Residential Services to complete its assessment of appropriate placement possibilities the following information should be submitted with this application:

_____ Copy of Current Treatment/Permanency Plan
_____ Educational Records
_____ Other Diagnostic Documentation (i.e. discharge summaries, testing)
_____ Admission Assessment with Social/Family History
_____ Current Psychological Evaluation
_____ Court Records (if applicable)

* *

Referring Agency: ____

Address: ______________________________________ Phone: ______________

Person Making Referral: ______________________ Signature: ______________________

Date of Referral: ______________________ Date Placement needed: ______________________

TOUCHSTONE
RESIDENTIAL SERVICES

CONSENT FOR TREATMENT

I give consent to TOUCHSTONE RESIDENTIAL SERVICES to provide services as agreed upon in the service authorization, to enroll in school and to authorize any routine or emergency medical, surgical, psychiatric, or psychological treatment that in the opinion of TOUCHSTONE RESIDENTIAL SERVICES is deemed to be necessary for the well being of:

_____ _____

(Child Name) Date of Birth

I also have been informed and understand that TOUCHSTONE RESIDENTIAL SERVICES will inform the consumer, parent, and/or legal guardian of any pending treatment that is elected and obtain consent except that it should be in the case of a life threatening emergency, at which time TOUCHSTONE RESIDENTIAL SERVICES will act upon the advice of the attending physician. Notification will then be made as soon as possible to the parent/legal guardian.

I understand that this consent is voluntary and that I may revoke this consent at any time by notifying or having an advocate notify TOUCHSTONE RESIDENTIAL SERVICES in writing.

I have read and understand the above statement and do hereby give my consent.

_____

(Printed Name of Consumer, Parent and/or Legal Guardian)

_____ _____

(Signature of Consumer, Parent and/or Legal Guardian) Date

_____ _____

(Witness) Date

TOUCHSTONE
RESIDENTIAL SERVICES

AUTHORIZATION FOR SERVICES

In accordance with the contract between _____ and *TOUCHSTONE RESIDENTIAL SERVICES, TRS* agrees to provide services for and authorization is hereby given by the parent or legal custodian for *TOUCHSTONE RESIDENTIAL SERVICES* to obtain any routine or emergency medical, psychological, psychiatric treatment deemed necessary, to enroll in school and to provide care for

_____
Child's Name

Date of birth: (Month/Day/Year) _____ Sex: Male _____ Female _____

Social Security Number: _____ Case number: _____

County of Legal Responsibility: _____

Placed On: (Date) _____

Department: Child Residential

In case of illness or accident, the contractor will notify the parent or legal custodian as soon as possible. In the case of a life threatening emergency *TOUCHSTONE RESIDENTIAL SERVICES* will act upon the advice of the attending physician. The authority is granted to the contractor to give informed consent for necessary emergency medical or surgical procedures.

The contractor will not incur any medical expenses, with the exception of emergency medical service, without prior approval of the parent or legal custodian.

The contractor will not permit the child to leave the control of the Agency or take the child outside North Carolina without prior approval of the parent or legal custodian.

Signature of Parent or Legal Custodian Date

Date

Agency Representative

Agency Address City, State, and Zip code

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

Date _____ Record # _____
(Same as Admission Date)

Social Security # _____ Phone number: _____

Mailing Address: _____

_____

Client accompanied by_____
NAME AND RELATIONSHIP

Copy of Medicaid Card?: Y/N Consent Signed?: Y/N

Date of Birth: (month-day-year)	Sex: (Please check one)	Unique ID: (1st three letters of last name (maiden if female) 1st initial and date of birth (month-day-year)
	☐ M ☐ F ☐ U	

Ethnicity:	☐ A=American ☐ M=Hispanic, Mexican American ☐ H=Hispanic, Other ☐ N=Not Hispanic ☐ P=Puerto Rican ☐ C=Cuban ☐ U=Unknown
Race:	☐ B=Black ☐ W=White ☐ I=American Indian, Alaskan Native ☐ A=Asian or Pacific Islander ☐ O=Other ☐ U=Unknown
Referral Source:	☐ 1=Self or no referral ☐ 10=Family or Friend ☐ 21=Nonstate residential/outpatient ☐ 22=State Facility ☐ 23=Psychiatric Service ☐ 32=Non-residential treatment/habilitation program ☐ 41=Private Physician ☐ 44=Nursing home board and care ☐ 46=Veteran's Administration ☐ 48=Other health care ☐ 60=Community Agency ☐ 71=Court, corrections, prisons ☐ 80=Schools ☐ 99=Other
Primary Language:	☐ E=English ☐ F=French ☐ S=Spanish ☐ L=Sign Language ☐ O=Other ☐ N=None ☐ U=Unknown

Reason(s) for seeking services and goals for treatment (Presenting Needs):

_____

_____

_____

_____

_____

_____

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name: _____ Medicaid number: _____

Biological / Developmental and Medical

Sleep: ☐ Normal ☐ Increased ☐ Decreased ☐ Restless.

Appetite: ☐ Normal ☐ Increased ☐ Decreased.

Sexual Behavior: ☐ Appropriate ☐ Inappropriate ☐ N/A

Other/Additional Information: _____

Encopresis: ☐ Not present ☐ Present and ☐ Increased ☐ Decreased

Enuresis: ☐ Not present ☐ Present and ☐ Increased ☐ Decreased

Weight change: ☐ None ☐ Increase in past _____ days/ weeks/ months

☐ Decrease in past _____ days / weeks/ months

Auditory:

☐ No Impairment ☐ Hearing Loss in ___ Right Ear, ___ Left Ear, ___ Both

☐ Uses hearing aid or other hearing device, if checked give more information

_____

_____

Visual:

☐ No impairment ☐ Farsighted ☐ Nearsighted ☐ Glasses ☐ Contacts

Additional Information: _____

Significant Medical Information:

☐ Asthma. ☐ High Blood Pressure.

☐ Heart Conditions. ☐ Physical Disability. ☐ Pregnant. ☐ Seizures. ☐ Diabetes

☐ Traumatic Brain Injury or Head Trauma ☐ Dental needs.

Other/Additional Information: _____

_____

Date of Last Physical Exam: _____

Allergies: _____

Current Medical Provider: _____

Date / Results of last TB skin test: _____

Date / Results of HIV test: _____

Current Medications and Prescribing MD: _____

_____

_____

_____

_____

_____

_____

Past Medications: _____

_____

_____

_____

Previous Hospitalizations &/or Surgeries: _____

_____

_____

ADDITIONAL INFORMATION RELEVENT TO BIOLOGICAL / MEDICAL HISTORY:

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

B. Psychological –significant stressors impacting the individual's functioning, ability to deal with stressful situations in the past, client's vulnerabilities and factors supporting resiliency. Include history of mental health treatment (e.g., inpatient, outpatient, medications) and response to treatment.

Emotional Health/Current Symptoms

☐ Depression, Adjustment problems

☐ Suicide/Self harm

☐ suicidal ideation ☐ plan ☐ intent ☐ means ☐ self-injurious behavior ☐ Other harmful behavior

☐ Stress, Anxiety

☐ Trauma

☐ Mania

☐ Psychosis

☐ Cognitive Impairment

☐ Substance Abuse/Use

☐ Behaviors:

☐fire setting ☐abuse to animals ☐physically aggressive ☐verbally aggressive
☐running away ☐impulsivity ☐lying ☐stealing ☐other:_____
Additional information:_____

☐ Other concerns related to emotional health:

☐loss/grief difficulties ☐low self-esteem ☐anger issues ☐other:_____
Additional information:_____

Hx of Mental Health Treatment

Outpatient (Describe):_____

_____

_____

Inpatient (Describe):_____

_____

_____

Hx of Trauma:

☐ Assault ☐ Rape ☐ Shooting ☐ Physical abuse as a child ☐ Spousal Abuse
☐ Auto Accident ☐ Robbery ☐ Sexual abuse as a child

Clarification or other:_____

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

D. Familial –family supports, family history of mental illness, significant events from client's history in relation to their family (e.g., abuse, neglect, adoption), and strengths and vulnerabilities with regard to current family situation.

Family History of Substance Abuse: ☐ Unknown ☐ Yes ☐ No Describe:_____

_____

_____

Family History of Mental Illness: ☐ Unknown ☐ Yes ☐ No Describe:_____

_____

_____

Family History of Legal Problems: ☐ Unknown ☐ Yes ☐ No Describe:_____

_____

_____

Specific Family of Origin History:

Number of Siblings Sisters_____ Brothers_____

Client Sibling Order ☐ Oldest ☐ Middle ☐ Youngest Other:_____

Who Raised/Raising Client: ☐ Parents ☐ Grandparents ☐ Foster Parent Other _____

Parent/Caretaker ☐ Separated ☐ Divorced ☐ Married ☐ Unmarried ☐ Deceased

Age client left home: _____

Does Client have any good or positive relationships from his/her family? If yes, who? _____

_____

ADDITIONAL INFORMATION RELEVENT TO FAMILIAL HISTORY:

E. Social –social history and current situation with regard to education, vocation, significant relationships (either positive or negative), involvement in the community and ability to make satisfactory adjustments in independent living, recreation activities, hobbies.

Education History:

Highest Level of Education Completed: _____

Current Grade/School:_____

Special Education / IEP: _____

Attitude Towards School: _____

Other: _____

Employment History:

☐ Currently Employed ☐ On Disability ☐ Frequently Fired

☐ Unemployed ☐ Desires Employment ☐ Desires change in employment

☐ Retired ☐ Military ☐ Desires Vocational Training ☐ Student

Clarify Vocational History: _____

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

Financial:

☐ Medicaid/Medicare/Private Insurance ☐ Stable Income
☐ Stable Employment ☐ Needs food assistance ☐ Needs financial assistance
☐ Needs financial/budgeting skills Comments:_____

Relationship Information:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Annulled ☐ Domestic Partners

Environmental/Client lives with: ☐ Stable housing ☐ Safe housing
☐ Safe neighborhood/community ☐ Biological Parent(s)
☐ Foster Parent(s) ☐ Family Member ☐ Other relatives
☐ Staffed home/facility (level) _____ Comments/Other: _____

Children:

☐ None ☐ Male How Many? _____ Ages? _____
☐ Female How Many? _____ Ages? _____
Other _____

Relationship Problems

☐ None Known ☐ Conflicts, with whom? _____
☐ No Friends ☐ Running away from home ☐ Family Desertion
☐ Separation or Divorce ☐ Visitation or Custody Dispute ☐ Child Neglect
☐ Child Abuse ☐ Death in Family ☐ No significant relationships.
Clarify or Other: _____
(Map relationships on People Map)

Community Involvement:

☐ Church / Synagogue ☐ Civitan Organizations
☐ Volunteer Organizations ☐ Recreation Leagues ☐ School Extracurricular Activities
Clarify or Other: _____

Hobbies or Special Interests: _____

F. Legal Status (e.g., juvenile court involvement/history, adult court involvement/history, illegal behavior, pending charges, probation):

☐ No Known Legal Problems
☐ Past Legal Problems _____
_____
_____
☐ Current Legal Problems _____
_____

Probation officer and phone number: _____

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

ADDITIONAL INFORMATION

Other agencies currently working with client? NO YES (if yes, list and obtain releases)

Treatment acceptance

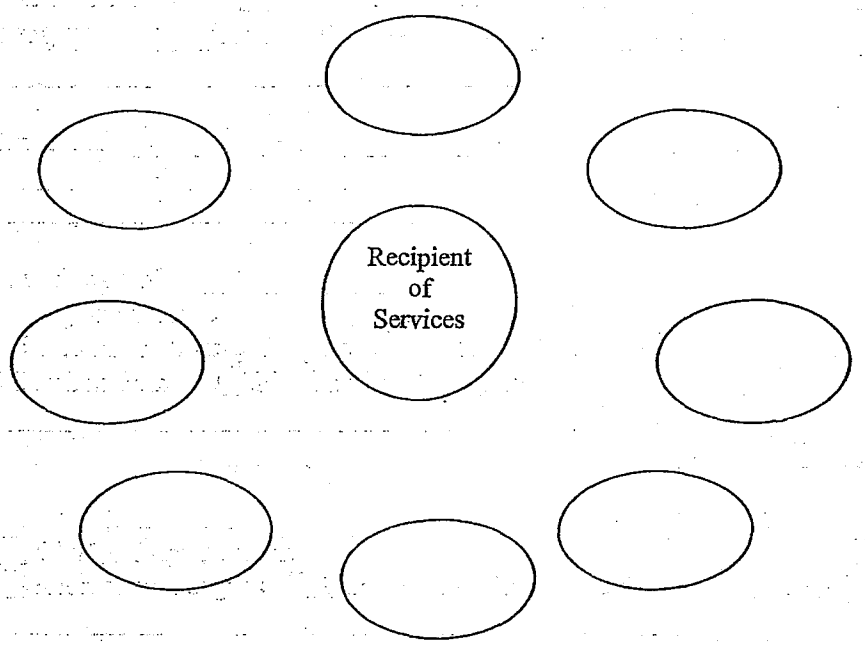
Does client acknowledge problem(s)? ☐ Yes ☐ No

Does client recognize need for treatment? ☐ Yes ☐ No, then explain:_____

Is client confident in MH services? ☐ Yes ☐ No

Is client a good treatment candidate? ☐ Yes ☐ No

PEOPLE MAP



Legend:

→ Direction the relationship flows. Could point either direction if the relationship is one sided with communication

↔ Both parties communicate with one another and relationship is Positive.

IIIII Relationship is tense and limited communication or communication is negative.

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

Complete this section for consumers with Developmental Disabilities:

1 = Independent, 2 = Minimal Verbal Prompting, 3 = 2 or more VP, some Physical Assistance, 4 = Mostly Physical Assistance, 5 = Total Assistance / Hand over hand

Daily Living Skills

Personal Care	☐1	☐2	☐3	☐4	☐5
Ability to care for Personal Space	☐1	☐2	☐3	☐4	☐5
Individual can feed self	☐1	☐2	☐3	☐4	☐5
Individual can prepare simple meal	☐1	☐2	☐3	☐4	☐5
Individual can make a purchase in the community	☐1	☐2	☐3	☐4	☐5

Communication skills

Individual uses 50 or more words	☐1	☐2	☐3	☐4	☐5
Individual can follow multiple step directions	☐1	☐2	☐3	☐4	☐5
Individual can express wants/needs clearly	☐1	☐2	☐3	☐4	☐5
Individual can answer Who, What, When, Where and Why questions?	☐1	☐2	☐3	☐4	☐5
Individual can read/write	☐1	☐2	☐3	☐4	☐5

Social Skills

Maintains eye contact when speaking or being spoken to	☐1	☐2	☐3	☐4	☐5
Individual engages in reciprocal play / conversation	☐1	☐2	☐3	☐4	☐5
Individual has friends / peer group	☐1	☐2	☐3	☐4	☐5
Individual follows rules of school/work/home	☐1	☐2	☐3	☐4	☐5
Individual can climb stairs	☐1	☐2	☐3	☐4	☐5
Individual can run/jump	☐1	☐2	☐3	☐4	☐5

Fine Motor Skills

Individual can pick up small object with thumb and fingers	☐1	☐2	☐3	☐4	☐5
Individual can transfer object from one hand to the other	☐1	☐2	☐3	☐4	☐5
Individual can cut with a pair of scissors	☐1	☐2	☐3	☐4	☐5

Health / Safety Skills

Individual knows address/phone number	☐1	☐2	☐3	☐4	☐5
Individual can recognize emergency situations	☐1	☐2	☐3	☐4	☐5
Individual knows how to dial 911	☐1	☐2	☐3	☐4	☐5

Decision making Skills

Individual can make complex choices/decisions for self	☐1	☐2	☐3	☐4	☐5

Additional Needs / Information:

_____

_____

_____

_____

Touchstone Residential Services

Intake Admission Assessment

(9-1-09)

Client name:_____ Medicaid number:_____

Recommendations:
Client would benefit from education in the following areas (check all that apply):

- ☐ Social skills
- ☐ Communication skills
- ☐ Anger management skills
- ☐ Coping skills
- ☐ Parenting skills
- ☐ Interpersonal/Relational skills
- ☐ Behavior Management skills
- ☐ Impulse Control
- ☐ Other _____
- ☐ Other _____

Contact was made for the specific purpose of arranging for appropriate services and lead to effective service delivery. This form serves as the documentation/service note.

Total Time: _____

Printed Name of QP:_____

Signature:_____

Date:_____

Disposition:

- ☐ There is known or suspected MH, SA, and/or DD Diagnosis OR
- ☐ Initial Screening/Intake Assessment Information indicates a need for additional MH/SA/DD treatment supports OR
- ☐ Person does not meet Entrance Criteria. Person was referred to_____

_____

_____

Initials of Guardian: _____

TOUCHSTONE
RESIDENTIAL SERVICES

INFORMED ACKNOWLEDGEMENT AND VOLUNTARY AGREEMENT FOR SERVICE DELIVERY FOR TFC
(REVISED 6/13/11)

Program: _____ Date: _____

Name of Individual: _____

Name of Legal Guardian: _____

1. After clear explanation of the program structure, rules and expectations, I agree for _____ to receive services from the _____ Program. I understand that this agreement is voluntary and that this agreement may be withdrawn by written notification at any time without prejudice or reprisal.

2. I agree to allow Touchstone Residential Services, Inc.'s staff to implement professionally accepted methods of intervention as indicated by _____ current and approved Treatment Plan (PCP) until such time that subsequent plans are developed and authorized by specific Informed Consent and Authorization Agreement.

3. As parent/guardian/consumer, I agree to participate and assist with the implementation of all goals, Behavior Plan and procedures developed to assist the consumer in their progress toward their goals. I agree to cooperate with all service providers and those involved in treatment.

4. I have received a full explanation of the no restraint policy. Staff will receive training on NCI part A and CPR-First Aid, annual training will occur. Non-restrictive Intervention training: approved de-escalation that includes teaching of non-physical skills in order to prevent the use of restrictive interventions.

5. I grant permission for this individual to participate in all program (community integration, leisure, vocational, social and educational) outings with the knowledge that such outings require his/her being transported.

Individual's Name: _____ Record#_____

Initials of Guardian: _____

6. I hereby give consent for transportation by Touchstone Residential Services, Inc. in any vehicle provided by or for Touchstone Residential Services, Inc. I understand that it is necessary for staff to transport individuals in private vehicles to/from program activities.

7. I authorize Touchstone Residential Services, Inc. trained staff to provide and render First-Aid and CPR intervention to the individual indicated above as needed in any program, facility or during outings if there is an emergency.

8. Financial agreements: Touchstone Residential Services will have a financial agreement for those individuals that receive SSI benefits and live in residential setting (Group Home, AFL or Therapeutic Foster Care) and have chosen TRS as their designated payee. In compliance with SSI regulations, these funds are intended for room and board, clothing, personal expenses and State spending money, but will not exceed the amount of the SSI benefit check.

9. I authorize Touchstone Residential Services, Inc. to obtain emergency medical, dental or mental health care for this individual, if needed, until such time that I can be reached to authorize further care.

10. I understand that while receiving services, situations may arise which, as the last possible alternative, certain limitations of rights and /or environmental limitations may be necessary to protect the health and safety of those in the home or program. In these cases, specific rights restrictions or limitations will be explained to the individual and legal guardian. The opportunity will be given to agree or refuse the restrictions/limitations.
    a) If the restriction is agreed to, a specific consent form will be explained to and signed by the individual or legally responsible person that indicates:
        1. Specific restriction
        2. Reason for restriction
        3. Benefits to the individual
        4. Risk to the individual
        5. Statement of understanding
        6. Guardian signature
        7. Date valid
        8. Human Rights Committee approval and Qualified Professional or Physicians authorization
        9. Follow-up and/or fading timeline

b.) If the restriction is refused, you will be afforded all entitled due process review/protections.

The Human Right Committee will be responsible for reviewing and approving the rights restrictions or environmental limitation and to provide continual review and approval on

Individual's Name: _____Record#_____

at least a quarterly basis to ensure that the least restrictive protective measure is being utilized.

11. I understand that trained staff of Touchstone Residential Services, Inc. will supervise the administration of all medication required during program or service delivery hours as ordered by a licensed medical practice practitioner. I understand that no over the counter medications for medical conditions or prescription medication to treat mental illness or behavior disorder can be administered to the individual without consent and authorization except in the case of a medical emergency.

12. I have been advised and understand that all information regarding the individual is protected by Stated and Federal Law. Any information released must be in accordance with specific authorization and consent from the individual or legally responsible person. I have been advised and understand that in certain specified instances, information may be disclosed without consent of the individual or legally responsible person. There instances include but are not limited to:
    a. Court Order
    b. Medical emergency;
    c. Imminent danger to the health/safety of the individual/others is suspected;
    d. Authorized audit or program evaluation;
    e. Felony or misdemeanor has occurred or is likely to occur;
    f. Abuse, neglect, or exploitation requirements for reporting to appropriate authorities.

13. I agree to be financially responsible for any prescription medications for this individual not paid by Medicaid, insurance, other resources or entitlements unless other arrangements have been authorization.

14. I have been informed and I understand that I will be notified of any serious illness or injury, any change in medical status or change in medication treatment to this individual.

15. I have been provided with a written summary of Client Rights as specified in *NCGS 122-C and APSM 95-2,*

16. I understand that I have the right to contact *Disability Rights NC* at 1800-821-6922.

17. I have been advised of the house rules and expectations and possible consequences.

18. I have been advised of the protections in place regarding release and disclosure of confidential information.

Individual's Name: _____ **Record#**_____

Initials of Guardian: _____

19. I have been advised of the procedures for obtaining a copy of the Treatment/Habilitation Plan and Discharge Plan.

20. I have received a copy of the following (unless requested otherwise): (see handbook)
    a. **Grievance Policy and Procedures**
    b. **HIPAA- Notice if Privacy**
    c. **Fee Assessment and Collections Policy (if applicable)**
    d. **Suspension and Expulsion Policy and Procedure**
    e. **Search and Seizure Policy and Procedure.**

21. I have been advised and I understand Touchstone Residential Services, Inc NO Restraint Policy for the Therapuetic Foster/Foster Care Program, which restricts the use of any use of restraints to manage aggressive behaviors.

22. I understand that in a 24 hour NC licensed facility, the individual receiving services must receive 24- hour supervision which includes both home and community, unless otherwise indicated in the plan and ordered by the physician. The responsible person who signs a consumer out of a 24 hour facility (including AFL's and Therapeutic Foster Care) must sign a TRS Release of Responsibility form. Once this has been completed, the consumer may leave the premises with the responsible party and their appropriate medications.

23. I understand that this document may be amended on an "as needed" basis. Any such amendment requires this consent for service delivery to be signed, dated, and witnessed by the individual or legally responsible person.

24. I have read the terms and agreement of this Informed Acknowledgement and Agreement for Service Delivery and Notification of Human Rights or had them clearly explained and understand and accept them as stated or amended as specific below. This agreement will expire one year after the date on which it is signed.

Statement of Understanding

I, _____, am responsible for _____
Guardian
_____, who is involved in Touchstone Residential Services,
Individual being served
Inc's _____ Program, and I have been explained rights in a way that I understand and the above mentioned policies have been given explanation to my satisfaction.

Individual's Name: _____Record#_____

Initials of Guardian: _____

Agreement Signatures:

Expiration date of this **Informed Acknowledgement and Voluntary Agreement for Service Delivery/ Notification of Rights** is valid for one year form the date signed below unless otherwise stated:_____.

Individual Receiving Services:_____ **Date:**_____

Legal Guardian:_____ **Date:**_____

Witness:_____ **Date:**_____

Amendments:

Date of Revocation:_____

Amendment/Revocation Signatures:

(Verbal revocation is acceptable but signatures are preferred.)

Individual Receiving Services:_____ **Date:**_____

Legal Guardian:_____ **Date:**_____

Witness:_____ **Date:**_____

Individual's Name: _____**Record#**_____

Annual Consents

TFC
Revised 7-18-11

Client's Name: _____ **Medical Record #:** _____ **Medicaid #:** _____

☐**AHR** ☐**CHS** ☐**TRS**

This consent is valid for no more than 1 year unless otherwise indicated for a time period less than 12 months.

Treatment

Initial Each Item:

_____ 1. Informed Consent for Treatment: (Valid for 1 year or until _____)

I acknowledge that information has been provided to me regarding the alleged benefits, risks, and possible alternative methods of receiving treatment services from this agency. A representative of this agency has explained the anticipated procedures and course of treatment to me. This consent for treatment is to be valid for **one year** (no more than 1 year). I understand that this consent may be withdrawn at any time, by submitting a written request to the assigned Qualified Professional. My signature below grants permission for the agency to provide treatment services to the client named above for as long as this consent is valid.

*** Each voluntary client or legally responsible person has the right to consent to or refuse treatment/habilitation in accordance with GS 122C-57(d). A voluntary client's refusal of consent will not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available from this agency. The agency will make the determination.**

_____ 2. Consent to Seek Emergency Medical Care/Dental Services: (Valid for 1 year or until_____)

I give permission for this agency to seek emergency care or emergency dental services for the client named above from the closest medical care provider available. In the case of an extreme emergency, and I cannot make the conscious decision, I give the attending physician permission to provide sufficient care that is needed until I can make the decision myself.

_____ 3. Release of Liability - Transportation: (Valid for 1 year or until _____)

I have read, understand, and agree to the following: In order for the provider to utilize their own or your vehicle in connection with their assignment to you, please be advised that the staff does not have insurance to cover use of provider owned vehicles or provider use of client owned vehicles while on assignment. To secure the services of this agency in this respect, we ask that you agree to release and hold them harmless. For any provider assigned to you by the agency from claim or action which you or those for whom you are responsible may have from bodily injury, including death, or property damage arising out of the use by the provider of any vehicles in connection with their assignment with you, specifically provided; however that any said claim or cause of action for bodily injury, including death, or property damage does not result from and/or arise out of any negligent or intentional act of this agency, its providers, agents or representatives.

*This is the last 3 pages of the agency ***Handbook.***

Annual Consents

TFC

Revised 7-18-11

Client's Name: _____ **Medical Record #:** _____ **Medicaid #:** _____

☐ **AHR** ☐ **CHS** ☐ **TRS**

This consent is valid for no more than 1 year unless otherwise indicated for a time period less than 12 months.

Initial each item:

_____ 4. Consumer Choice: I choose to have services from this agency. (Valid for 1 year or until _____)

I acknowledge that I have been given an opportunity to review a list of providers and the services they provide in the area in which I live. I understand that only medically necessary services will be authorized. I have been informed of the appropriate and available providers in the network that would meet my specific needs for services, location, and hours of availability.

I understand it is my choice to select a provider that is endorsed to address my needs and that I can alert my provider if I would like to change providers at any time. I can also call the LME Consumer Rights or the Division of Mental Health to request assistance if I experience any difficulty with changing my provider.

_____ 5. Permission to Use Pictures and Video: (Valid for 1 year or until_____)

I hereby give this agency the right and permission to publish, copyright and use pictures of me in which I may be included in whole or part, composite or retouched in character or form, in conjunction with my own name and no name being used. If the person photographed is under 18, I certify that I am his or her parent or legal guardian and I give my consent without reservation to the foregoing on his or her behalf.

_____ 6. Release of Information To Third Party Payors: (Valid for 1 year or until _____)

I hereby authorize this agency to release information from my client service record to my insurance company, Medicaid, or Medicare in order to process and pay claims for services rendered to me. I understand that this consent allows release of all information in my client record including, substance abuse, communicable diseases (including AIDS/HIV), and other sensitive documentation.

_____ 7. Assignment of Benefits: (Valid for 1 year or until _____)

I hereby authorize payment directly to this agency of any insurance or government program benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not paid under this assignment. Any refunds due me shall be applied to any other outstanding balance for which I am responsible with this agency.

_____ 8. No Restraint Policy: (Valid for 1 year or until _____)

I have been explained that Touchstone Residential Services shall not engage in discipline or behavior management that includes: protective or mechanical restraints, drug as a restraint, seclusion of a child in a locked room or physical restraint holds.

*This is the last 3 pages of the agency ***Handbook.***

Annual Consents

TFC

Revised 7-18-11

Client's Name: _____ **Medical Record #:** _____ **Medicaid #:** _____

☐**AHR** ☐**CHS** ☐**TRS**

This consent is valid for no more than 1 year unless otherwise indicated for a time period less than 12 months.

Informing of Rights & Rules

Initial each item:

_____ I have received the Consumer Handbook which includes:

—— **I have been given information concerning my Client Rights and explained in a way that I could understand.**

—— **I have been provided with information on the no restraint policy, search and seizure and other information related to my health and safety.**

—— **I have been given the Notice of Privacy information.** We provide this Notice to each consumer beginning no later than the date of our first service delivery to the consumer, including service delivered electronically, after April 14, 2003. We make a good-faith attempt to obtain written acknowledgement of receipt of this Notice. We also have the Notice available at the office for consumers to request to take with them. We post the Notice in our office in a clear and prominent location where it is reasonable to expect any consumers seeking service from us to be able to read the Notice. Whenever the Notice is revised, we make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions.

—— **I have received information on Advanced Directives.**

—— **I have been provided information on issuing a complaint and procedures that include the fact that if a complaint is filed in good faith, the agency will not retaliate, humiliate or negatively impact your services.**

This consent is not valid for more than one year or until which time it is revoked.
I would like to revoke my consent for : _____ on this date: _____.

Acknowledgement

I certify the above information has been explained to me so that I may understand it clearly. I certify I had the opportunity to ask questions, and they have been answered. I further acknowledge receipt of the above information in writing, upon my admission date / annually.

_____ _____
Client or Legally Responsible Person's Signature Date

_____ _____
Agency Representative Signature Date

_____ _____
Witness Date

*This is the last 3 pages of the agency ***Handbook.***